WOMEN'S HEALTH QUESTIONNAIRE

Gynecological History

Date of last pelvic exam _____ Results _____

Date of last pap-smear _____ Results _____

Have you ever had an abnormal pap-smear? ☐ No ☐ Yes, treatment _____

Are you sexually active? ☐ No ☐ Yes Are you trying to get pregnant? ☐ No ☐ Yes

Current birth control method _____ Problems with it? _____ How long? _____

Past birth control and any related problems _____

Age of first period _____ Date of last period _____

How many days from start of one period to the start of the next? _____

Number of days of flow _____ Amount of Bleeding _____ Amount of cramps _____

Premenstrual symptoms _____ Start & end when? _____

Any current changes in your normal cycle? ☐ No ☐ Yes, explain _____

Any bleeding between periods? ☐ No ☐ Yes, when? _____

Any pelvic pain, pressure or fullness? ☐ No ☐ Yes, describe _____

Any unusual vaginal discharge or itching? ☐ No ☐ Yes, describe _____ Treatment? _____

Age at first pregnancy _____ How many full-term pregnancies? _____

Pregnancy problems? _____

Any iterated pregnancies (miscarriages or abortions)? ☐ No ☐ Yes

Have you had a tubal ligation? ☐ No ☐ Yes, when? _____

Have you had any part of or a whole ovary removed? ☐ No ☐ Yes

Have you had a hysterectomy? ☐ No ☐ Yes, when? _____

Do your ovaries remain? ☐ No ☐ Yes

WOMEN'S HEALTH QUESTIONNAIRE

General Health Evaluation

Have you experienced any of the following recently? Circle the number that best describes your experiences on a scale 0 - 10.
(For example: 0 = non-existent, 1 = very mild, 10 = extremely severe)

Severity	**None**										**Extreme**
Sleep Disruptions	0	1	2	3	4	5	6	7	8	9	10
Fatigue	0	1	2	3	4	5	6	7	8	9	10
Vaginal Dryness	0	1	2	3	4	5	6	7	8	9	10
Irritability	0	1	2	3	4	5	6	7	8	9	10
Nervousness	0	1	2	3	4	5	6	7	8	9	10
Breast Tenderness	0	1	2	3	4	5	6	7	8	9	10
Hot Flashes	0	1	2	3	4	5	6	7	8	9	10
Dry Skin	0	1	2	3	4	5	6	7	8	9	10
Mood Swings	0	1	2	3	4	5	6	7	8	9	10
Arthritis	0	1	2	3	4	5	6	7	8	9	10
Loss of Recent Memory	0	1	2	3	4	5	6	7	8	9	10
Weight Gain	0	1	2	3	4	5	6	7	8	9	10
Decreased Sex Drive	0	1	2	3	4	5	6	7	8	9	10
Depression	0	1	2	3	4	5	6	7	8	9	10
Fluid Retention	0	1	2	3	4	5	6	7	8	9	10
Headaches	0	1	2	3	4	5	6	7	8	9	10
Night Sweats	0	1	2	3	4	5	6	7	8	9	10
Hair Loss	0	1	2	3	4	5	6	7	8	9	10
Harder to Reach Climax	0	1	2	3	4	5	6	7	8	9	10
Bladder Symptoms	0	1	2	3	4	5	6	7	8	9	10
Other:											
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10